VIRGINIA EMPLOYMENT COMMISSION
EMPLOYER'S REPORT OF SEPARATION AND WAGE INFORMATION

ACCOUNT NUMBER :

EMPLOYER NAME AND ADDRESS :

SOCIAL SECURITY NUMBER :
CLAIMANT NAME :
EFFECTIVE DATE :
REASON FOR SEPARATION :
DATE CLAIM TAKEN :
BENEFIT YEAR ENDING :

TO EMPLOYER: The individual has filed a claim for unemployment insurance and has named you as a former employer. The information requested below is required to determine the claimant's entitlement to benefits. IMPORTANT: Benefits may be awarded without your response unless this form is completed and received at the address on the reverse by

1. THE CLAIMANT STATES HE WORKED FROM TO IF INCORRECT, ENTER THE CORRECT DATES:
   FROM _____ TO _____.
2. DID THE CLAIMANT WORK DURING THE SEVEN (7) DAY PERIOD BEGINNING YES _____ NO _____
   AND ENDING ?
   IF 'YES', ENTER GROSS WAGES EARNED DURING THIS TIME PERIOD $ _____
3. DID THE CLAIMANT WORK FOR YOU FOR AT LEAST 30 WORKING DAYS? YES _____ NO _____
   IF 'NO', DID THE CLAIMANT WORK AT LEAST 240 HOURS? YES _____ NO _____

***NOTE: IF THE CLAIMANT WORKED 30 DAS OR MORE, DO NOT COMPUTE THE HOURS. IF LESS THAN 30 DAYS WAS WORKED, THEN YOU MUST DTERMINE IF THE CLAIMANT WORKED AS MANY AS 240 HOURS.**

4. HAVE YOU GIVEN THE CLAIMANT A DEFINITE RETURN TO WORK DATE? YES _____ NO _____
   IF 'YES', ENTER DATE _____
5. IS THE CLAIMANT ELIGIBLE FOR A PENSION FROM YOUR COMPANY? YES _____ NO _____
   IF 'YES', ENTER GROSS MONTHLY AMOUNT $ _____ AND START DATE _____
6. WILL THE CLAIMANT RECEIVE ANY OF THE FOLLOWING PAYMENTS ON OR AFTER THE LAST DAY OF WORK?

TYPE	GROSS AMOUNT	PERIOD COVERED FROM	TO
VACATION	$ _____	_____	_____
HOLIDAY PAY	$ _____	_____	_____
SEVERANCE	$ _____	_____	_____

   IF SEVERANCE IS PAID, IS THIS A LUMP SUM PAYMENT ASSIGNED TO THE LAST DAY WORKED? YES ____ NO ____
   IF 'NO', SPECIFY PERIOD COVERED FROM _____ TO _____
   INDICATE CLAIMANT'S DAILY RATE OF PAY: $ _____
   INDICATE NUMBER OF WORK DAYS PER WEEK _____
   INDICATE CLAIMANT'S AVERAGE WEEKLY WAGE DURING LAST CALENDAR QUARTER $ _____
   OTHER TYPE PAYMENT YES _____ NO _____ AMOUNT _____
   IF 'YES', WHAT TYPE OF PAYMENT _____. PERIOD COVERED FROM _____ TO _____
7. ENTER AN 'X' IN THE APPROPRIATE BOX TO INDICATE THE REASON FOR THE CLAIMANT'S SEPARATION FROM YOUR EMPLOY. ADDITIONAL QUESTIONS AND COMMENTS SHOULD BE COMPLETED ON THE REVERSE SIDE. IF ANY OTHER FACTS ARE KNOWN

____LACK OF WORK ____DISCHARGE _____VOLUNTARY QUIT _____SUSPENSION _____LEAVE OF ABSENCE

YOU, OR YOUR REPRESENTATIVE, AND THE CLAIMANT ARE REQUESTED TO PARTICIPATE. PLEASE PROVIDE THE NAME: _____ POSITION TITLE _____ OF THE INDIVIDUAL WHO WILL PARTICIPATE ON YOUR BEHALF, ALSO PROVIDE THE TELEPHONE NUMBER _____ WHERE THIS INDIVIDUAL CAN BE CONTACTED.

(PLEASE CONTINUE ON REVERSE SIDE)

IMPORTANT: IF YOU FAIL TO RESPOND TO THIS REQUEST OR SUBSEQUENT REQUESTS FOR INFORMATION, THE DECISION TO AWARD OR DENY BENEFITS WILL BE BASED ON INFORMATION CONTAINED IN THE RECORD.

THIS INFORMATION MAY BE DISSEMINATED TO OTHER GOVERNMENTAL AGENCIES SUBJECT TO THE VIRGINIA PROTECTION ACT FOR USE IN THE PROPER ADMINISTRATON OF LAW.

NOTE: ALL INFORMATION PROVIDED ON THIS FORM MAY BE SHARED WITH THE CLAIMANT.

CERTIFICATION: I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND THAT THE LAW PROVIDES PENALITIES FOR PROVIDING FALSE STATEMENTS TO ALLOW, PREVENT OR REDUCE THE PAYMENT ON UNEMPLOYMENT BENEFITS.

EMPLOYER NAME _____ VEC ACCT. NO. _____ PHONE _____

COMPLETED BY _____ TITLE _____ DATE _____

RETURN THIS FORM TO :